Remarks of Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
to
Manor Healthcare Corporation Executives

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Good morning, and thank you for the opportunity to speak with you today on the future of health care reform.

I think that no matter which candidate you voted for on Tuesday, we can all agree that the outcome of the election means that the prospects for meaningful health care reform have risen dramatically.

As a Democrat who has spent many long years battling an Administration that was indifferent when it came to health care issues, I am very excited that we now have a President, a Congress, and the American people all on the side of activism and progress.

Background

But before I talk about the future, I think we should look at where we've been. It's worth spending a few minutes reviewing what happened -- and didn't happen -- in the Congress that just ended, because it provides some clues as to what might happen in the year ahead.

First, and most obviously, nothing was enacted, despite the urgent need for reform. Why? Because no legislation as complex and as contested as health care reform can possibly be enacted without the active support of the Executive Branch.

President Bush and Secretary Sullivan succeeded in killing any chance of health care reform by spending the last 4 years attacking both employer choice and single payor models of reform as "government rationing," "government price controls," and "tax and spend."

The only legislative change that the Administration appeared willing to support was what they called "small group market reform." That was rejected by the Congress because it would have made insurance coverage even more unaffordable for small businesses, increasing the number of uninsured employees and dependents without making any headway against health care cost increases.

House Democrats, under the leadership of Dick Gephardt tried to bridge the gaps between several different comprehensive approaches:

-- employer choice plans -- "Pay or play" (Waxman/Rockefeller)
-- Single payor advocates (Russo, Dingell)
-- "Medicare for all" supporters (Gibbons, Stark)
-- "Managed competition" advocates (Cooper, Stenholm)

I believe that a great deal of progress was made in terms of understanding how to take significant pieces from all of the proposals. The Senate Democrats went through a similar process, and they too recognized the need for action. But without a chance of getting a decent bill signed, it was simply impossible to move forward.

Ever since I was first elected to the Congress in 1974, I have pushed for the enactment of legislation that would assure every American access to basic health care, including physician, hospital, and diagnostic services, as well as prescription drugs.

Next January, when the 103rd Congress convenes, I expect to work closely with President Clinton and the leadership of the House and Senate to secure enactment of health care reform.

And what I want is what I hear the American people saying they want from health care reform:

-- protection against the high costs of care,
-- guaranteed coverage for basic services,
-- choice of their own doctor,
-- and a way to pay for a health care system that is fair, doesn't hurt American competitiveness, and doesn't take benefits away from the elderly and the poor.

There are obviously different ways to get to this result. I am on record as supporting an employer mandate, an employer choice model (sometimes called pay or play), and a single collector plan.

The employer mandate proposal is clear. The so-called pay or play, or employer choice variation, requires employers to offer basic coverage to their employees and dependents, or pay to enroll their employees in a public program. This "play or pay" concept was at the heart of the Pepper Commission recommendations, which I supported and introduced as a bill last year, H.R. 2535.

But there was also interest in having on the table a proposal that put less of a burden on business. One way to relieve employers of the primary obligation of financing the health care of their employees, is to establish a single, publicly financed program that allows individuals to select their own qualified health plans, with a VAT tax as a major financing source. This is the model incorporated in the Dingell-Waxman bill, H.R. 5514.

In all of these proposals -- the Pepper Commission bill and Dingell-Waxman bill -- individuals are entitled to a defined package of basic health care benefits, and they have a range of choices as to the types of private providers and plans from which they will receive services.

Similarly, they also address the need for effective cost containment. The Pepper Commission bill would make Medicare-like rates available for use by private payors in order to give them more bargaining leverage with physicians and hospitals. The Dingell-Waxman bill would establish and enforce a national health care budget that would, over time, bring the rate of increase in health spending into line with growth in our economy by the end of this decade.

What is my point here? Not that I can't make up my mind. It is that access and cost containment can be achieved in many ways that would be acceptable to me. My bottom line is assuring that all Americans have access to basic health care services from a provider of their choice. Whether we get to this result using the employer choice approach or through a single collector approach is, for me, an issue of what is politically doable, not what is politically correct.

By the same token, we need effective cost controls. Our current strategy -- government reducing reimbursement under its own programs in order to limit its own expenditures -- is not the answer. This strategy doesn't solve the problem -- it just shifts it to private purchasers. Again, I'm not ideologically wedded to any particular cost containment methodology. The important point is that effective cost containment must apply across-the-board -- to the public and private sectors alike.

President-elect Clinton has made it clear that health care reform is among his highest priorities. He has proposed to improve access to basic health services by building on our employer-based system. He has proposed to control health care costs by setting an overall limit on health spending in each State. I expect that this proposal will be fleshed out over the next two months and introduced early next year. I am enthusiastic about working closely with the new Administration to enact legislation that will achieve universal coverage for basic health services and control costs.

Long Term Care

I'd like to turn briefly to an issue that I believe is the missing link in the debate about health care reform -- long-term care. Given the changing demographics of our nation, and the rapidly rising Medicaid spending on long-term care, it is clear to me that we will not have true health care reform until we address the long term care needs of our citizens.

As you may know, this year I introduced the Long Term Care Family Security Act with Majority Leader Dick Gephardt. Based on the recommendations of the Pepper Commission, this bill proposes a public program for home and community-based care and short term nursing facility stays. It also provides a floor of income and asset protections for longer nursing facility stays. All benefits are subject to cost containment and quality assurance mechanisms. Private long term care insurance policies for additional benefits are made eligible for favorable tax treatment if they meet Federal consumer protection requirements.

There has been considerable debate since introduction of this legislation about the financing for such a program of benefits. I'm not particularly wedded to one approach over another. But I think as a nation we need to come to terms with the fact that there will be no long-term care reform -- or health care reform, for that matter -- if we aren't willing to pay for it.

As the Governor of a poor State, Bill Clinton certainly understands this. Arkansas, like other States, has been struggling to control its Medicaid costs through a combination of benefit cuts, reimbursement cuts, and State employee furloughs. The Arkansas Medicaid director has made it clear that, despite these efforts, the Legislature will have to consider a tax increase to fund Medicaid next year.

It's obvious that for Arkansas and other States, something has to give. They simply don't have the revenue base to continue to finance the Medicaid program as it is now structured: a program of basic care for poor families, a program of long-term care for the elderly, and a program of specialized services for the disabled. The combination of an aging population and health care cost inflation will simply overwhelm the States at some point during the 90's.

As a Nation, we have two ways out of this box. We can take the Oregon trail to health care rationing for the poor, under which benefits will vary depending on the funds available to the State at any point in time. Or we can enact comprehensive health care reform, with the Federal government assuming financing responsibility for a fixed package of basic health care services for the poor. This will obviously free up State resources now spent on acute care for long-term care needs.

To me there is only one acceptable choice here: we must move ahead with comprehensive reform. I am committed to this, I believe President-elect Clinton is committed to it, and I hope and trust that many of you in this audience are committed as well.

I look forward to working with you as these issues play themselves out over the next Congress, and I'd be happy to answer any questions.